

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7951

CERTIFICATE OF DEATH

Reg. Dist. No.

07900

TO HOSPITAL or attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		c. LENGTH OF STAY IN 1b 11 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Paul	Middle	Last Arthur	4. DATE OF DEATH Month 7	Day 27	Year 1959		
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/1899	9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) manager		10b. KIND OF BUSINESS OR INDUSTRY shoe factory		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John E. Arthur		14. MOTHER'S MAIDEN NAME Minnie Morris							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Nellie Arthur, Middletown, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.3		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b.		Carcinoma of sigmoid with metastasis liver		INTERVAL BETWEEN ONSET AND DEATH -16yr			
DUE TO c.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Operation Dec 1958 (inoperable)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Middleton		20f. (City or town) Middleton		(County) Middleton	(State) Md.
21. I certify that I attended the deceased from Nov , 19 59 , to July 27 , 19 59 , that I last saw the deceased alive on July 27 , 19 59 , and that death occurred at 10 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Middleton		DATE SIGNED July 28 1959	
ACTUAL SIGNATURE J. Elmer Harp		M.D.							
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp				Middletown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/30/1959		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Middleton, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR JUL 31 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7950

CERTIFICATE OF DEATH

Reg. Dist. No.

07901

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician and completely filled in by the general director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 528 west Potomac		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick	
3. NAME OF DECEASED (Type or print) Beverly		First Ann	Middle Ayers
4. DATE OF DEATH 7		Month 7	Day 23
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-3-1935		9. AGE (In years last birthday) 24 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James C. Haller		14. MOTHER'S MAIDEN NAME Dorothy Haines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Donald Ayers, Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Brinsford	
ACTUAL SIGNATURE C. E. Pruitt		DATE SIGNED JUL 27 '59	
PHYSICIAN'S NAME (Type) C. E. Pruitt		Brunswick Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-25-59	
22c. NAME OF CEMETERY OR CREMATORIUM Park Heights		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elmer G. Pratt		ADDRESS Brunswick, Maryland	
		24a. REC'D BY REGISTRAR Cuthbert L. Thorne	
		24b. REGISTRAR'S SIGNATURE Cuthbert L. Thorne	

MANUFACTURER'S STATEMENT OF HEALTH - SAVANNAH CO., GA.

CERTIFICATE OF DEATH

Deceased's Name	Age	Date of Birth	Date of Death	Place of Death
John G. Smith	62	1888-01-01	1950-05-15	Hospital
Address				
123 Main Street, Savannah, Georgia				
Relationship to Deceased				
Son				
Cause of Death				
Heart Disease				
Time of Death				
10:00 AM				
Place of Death				
Hospital				
Name of Physician				
Dr. John G. Smith				
Name of Hospital				
Savannah General Hospital				
Signature				
John G. Smith				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

17902

791:

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 68 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Also Known As HARRY GILMOR BENSON) (Type or print) HARRY		4. DATE OF DEATH Last Month Day Year February 20, 1874	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 20, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY News Paper	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Benson		14. MOTHER'S MAIDEN NAME Alice Morford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-7205	17. INFORMANT Mrs. Minnie H. Benson—Same as Item #2
Address 157x			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 7 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) 3118, 1959, to July 18, 1959, at 8:45 A.M., from the causes and on the date stated above.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Professional Building
21. I certify that I attended the deceased from July 17, 1959 , to July 18, 1959 , that I last saw the deceased alive on July 17, 1959 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7/20/59	
ACTUAL SIGNATURE L. R. Schoolman		DATE SIGNED 7/20/59	
PHYSICIAN'S NAME (Type) Dr. Louis R. Schoolman		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 21, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland	24a. REC'D BY REGISTRAR DATE JUL 21 '59
			24b. REGISTRAR'S SIGNATURE Charles S. Evans

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7918

CERTIFICATE OF DEATH

Reg. Dist. No.

117903

TO HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

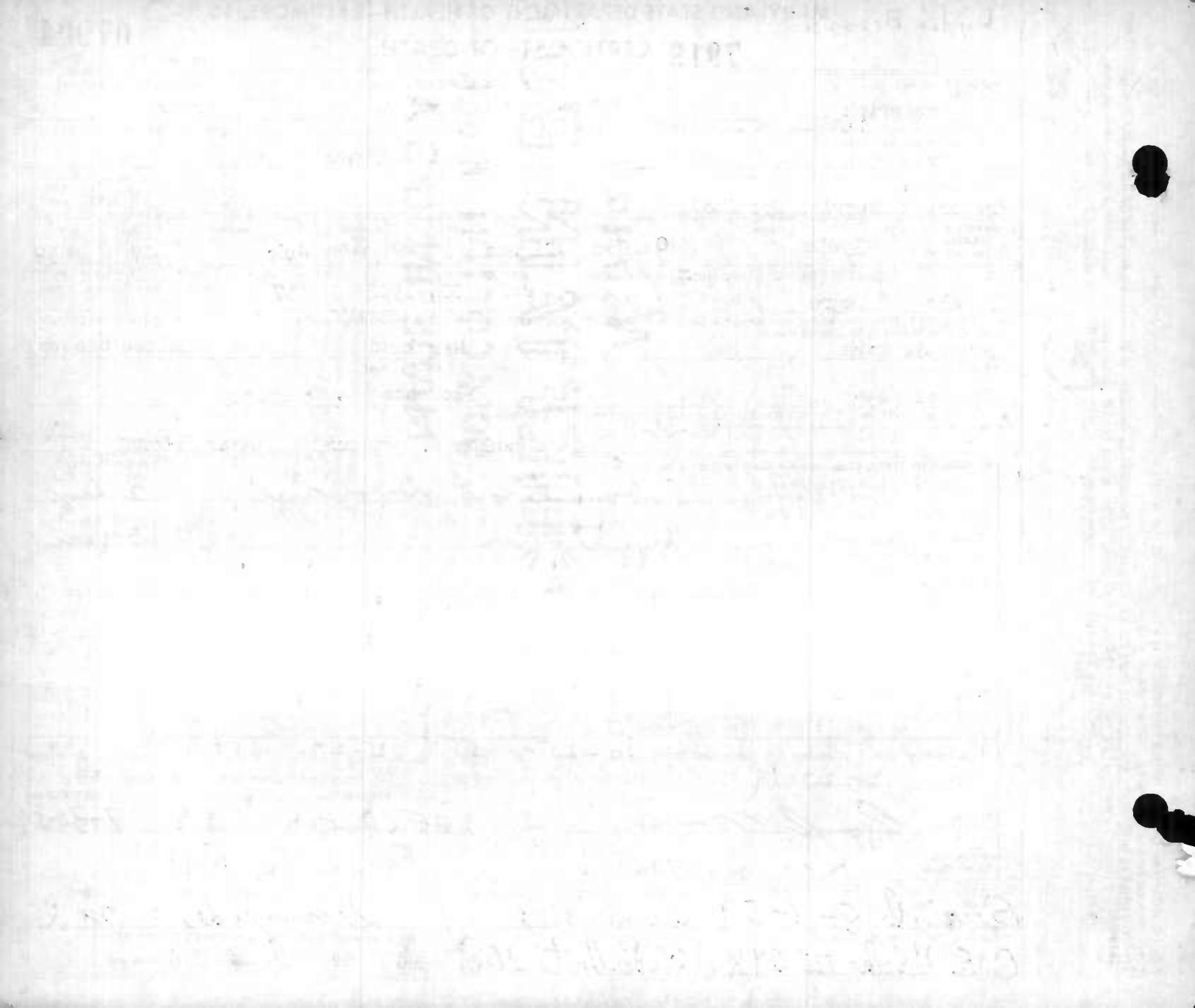
1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		Maryland		b. COUNTY		Carroll	
Frederick				c. LENGTH OF STAY IN 1b		20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Union Bridge	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		Frederick		d. LENGTH OF STAY IN 1b		20 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Union Bridge	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		c. LENGTH OF STAY IN 1b		20 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Union Bridge	
d. NAME OF HOSPITAL (If not in hospital, give street address)		Frederick Memorial Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
069		I						e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ANNA		Middle RUTH		Last Biddinger		4. DATE OF DEATH		Month July Day 10 Year 1959	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-19-17		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Bowerson Mr. Roy		14. MOTHER'S MAIDEN NAME Black, Margie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO.		17. INFORMANT ALTON BIDDINGER UNION BRIDGE		Address RURAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 194X DUE TO		Melanotic carcinoma of foot with metastasis to lymph nodes, liver, and abdomen. B carcinoma of thyroid with metastasis to neck glands and lung.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		It years									
DUE TO		B carcinoma of thyroid with metastasis to neck glands and lung.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 6-20, 1959, to 7-10, 1959, that I last saw the deceased alive on 7-10, 1959, and that death occurred at 11:55 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Frederick Md. DATE SIGNED 7/14/59									
ACTUAL SIGNATURE J. J. PEARRE M.D.											
PHYSICIAN'S NAME (Type) J. J. PEARRE											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 7/15/59		22b. DATE THEREOF 7/15/59		22c. NAME OF CEMETERY OR CREMATORIAL MT HOPE		22d. LOCATION (City, town, or county) WOODS Boro		(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE DN Hartman & Son Union Bridge Md		ADDRESS		24a. REC'D BY REGISTRAR JUL 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne					
VS A15 (4) IMS 9/55											

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7919 CERTIFICATE OF DEATH

Reg. Dist. No. 07904

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Frederick		c. LENGTH OF STAY IN 1b Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Urbana)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lydia		First	Middle Adella	Last Biggus	4. DATE OF DEATH July 27 1959	Month	Day	Year
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1902	9. AGE (In years from birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Charles Pace		14. MOTHER'S MAIDEN NAME Florence E. Thompson		INFORMANT		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-26-5825		Mahlon E. Biggus		Near Urbana		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X		Subarachnoid hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO Hypertension				5 years		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from 10-25-1955 , to 2-27-1959 , at 35 E Church , Frederick, Md., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)				DATE SIGNED 7-30-59		
ACTUAL SIGNATURE Rex R. Martin		M.D.						
PHYSICIAN'S NAME (Type) Rex R. Martin								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-59		22c. NAME OF CEMETERY OR CREMATORIAL Sunnyside		22d. LOCATION (City, town, or county) Sunnyside, Md		(State)
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III		ADDRESS 24 W. All Saints Street		24a. REC'D BY REGISTRAR Aug 3 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kline		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7920

CERTIFICATE OF DEATH

Reg. Dist. No.

07905

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		d. STREET ADDRESS <i>Thurmont</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Chronic Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Judson</i>		First	Middle	Lost	4. DATE OF DEATH <i>Boswell</i>	Month <i>July</i>	Day <i>12</i>	Year <i>1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1 1884</i>	9. AGE (In years lost birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Catonsville, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Judson Boswell</i>		14. MOTHER'S MAIDEN NAME <i>Martha Serrone</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-16-4442</i>		17. INFORMANT <i>Stephen Boswell Jr.</i>		Address <i>Route 6 Thurmont, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>		
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Arterio sclerosis</i>		(b)				3 mos.		
DUE TO <i>Senility</i>		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Senility</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Apr 25</i> , 19 <i>59</i> , to <i>July 11</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>July 11</i> , 19 <i>59</i> , and that death occurred at <i>12:55 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>H.F.Kline</i>				M.D. <i>7.11.1959</i>		ADDRESS (Street, city or town, state) <i>77 Market St Frederick, Md.</i>		DATE SIGNED <i>July 12, 1959</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/15/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Good Shepherd Cemetery</i>		22d. LOCATION (City, town, or county) <i>Elliott City, Md.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Easton Sons, Catonsville 28, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JUL 16 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles J. Kraus</i>		

TO HOSPITAL
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7952 CERTIFICATE OF DEATH

07906

Reg. Dist. No.

TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Monrovia		c. LENGTH OF STAY IN 1b years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Monrovia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 1						d. STREET ADDRESS R.F.D. 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosella		First	Middle	Last	4. DATE OF DEATH July 27		Month	Day	Year	1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1875		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Richard Chaney				14. MOTHER'S MAIDEN NAME Eveline Smith							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---- - --- - -		17. INFORMANT Robert E. Gue, Monrovia, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Larvinoma of stomach; generalized metastases DUE TO 151X INTERVAL BETWEEN ONSET AND DEATH 5 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO 10 years (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 7/1/59 , 1959, to 7/27 , 1959, that I last saw the deceased alive on 7/13 , 1959, and that death occurred at 11a. M. from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>James P. Kerr</i>						ADDRESS (Street, City or town, state) Damascus, Md.				DATE/SIGNED 7/27/59	
PHYSICIAN'S NAME (Type) James P. Kerr, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/59		22c. NAME OF CEMETERY OR CREMATORIAL Marvin Chapel		22d. LOCATION (City, town, or county) Plane # 4, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Molesworth</i>		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

CERTIFICATE OF DEATH

DECEASED'S NAME	SEX	AGE	CAUSE OF DEATH
WILLIAM H. COOPER	MALE	65	HEART DISEASE
ADDRESS			
101 N. 1ST AVENUE MIAMI, FLA.			
CITY, STATE, ZIP CODE			
MIAMI, FLA. 33102			
NAME AND ADDRESS OF FUNERAL HOME			
HAROLD L. COOPER, INC. 101 N. 1ST AVENUE MIAMI, FLA.			
NAME AND ADDRESS OF DOCTOR			
DR. RICHARD J. COOPER 101 N. 1ST AVENUE MIAMI, FLA.			
NAME AND ADDRESS OF ATTENDING NURSE			
NURSE MARY COOPER 101 N. 1ST AVENUE MIAMI, FLA.			
NAME AND ADDRESS OF PERSON PREPARING THIS CERTIFICATE			
DR. RICHARD J. COOPER 101 N. 1ST AVENUE MIAMI, FLA.			
DATE OF DEATH			
MAY 15, 1968			
TIME OF DEATH			
10:00 A.M.			
NAME AND SIGNATURE OF PERSON SIGNED			
DR. RICHARD J. COOPER			
SIGNATURE			
RICHARD J. COOPER			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7953 CERTIFICATE OF DEATH

107907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Knoxville		c. LENGTH OF STAY IN lb —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 35				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---				d. STREET ADDRESS 109 "A"				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Joseph	Middle E	Last Chow	4. DATE OF DEATH	Month 7	Day 30	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1881		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY County Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME <i>Don't know</i>		14. MOTHER'S MAIDEN NAME <i>Don't know</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Mary Chew, Brunswick, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) <i>Coronary Occlusion Death</i>								
INTERVAL BETWEEN ONSET AND DEATH 5 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>St. Paul</i>	(County)	(State)
21. I certify that I attended the deceased from <i>April 1, 1959</i> to <i>Aug 30, 1959</i> , that I last saw the deceased alive on <i>July 1, 1959</i> , and that death occurred at <i>St. Paul</i> M.D., from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>Knoxville, Maryland</i>								
ACTUAL SIGNATURE <i>J.G.F. Smith</i> DATE SIGNED <i>Sept 1, 1959</i>								
PHYSICIAN'S NAME (Type) J.G.F. Smith								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-2-1959		22c. NAME OF CEMETERY OR CREMATORIUM Reformed		22d. LOCATION (City, town, or county) Knoxville, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. L. Full</i>		ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE AUG 5 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		

TO HOSPITAL or attending physician and completely filled in by the general director,
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

J-93

*John F. Smith**John F. Smith*

TO HOSPITAL or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7921 CERTIFICATE OF DEATH

17908

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1, East 3rd Street				d. STREET ADDRESS 4 East 3rd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HAROLD		First	Middle	Last	4. DATE OF DEATH CRUM	Month	Day	Year			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1886	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Simon Henry Crum				14. MOTHER'S MAIDEN NAME Margaret Holbruner							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 5/25/18 6/10/19 214-10-4390		17. INFORMANT Mrs. Allen Jones (Niece)		Address 4 E. 3rd Street					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ONSET AND DEATH yes -											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour o. m. p. m. 19		Month	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Maryland	(State) MD		
21. I certify that I attended the deceased from July 21, 1959 , to July 29, 1959 , that I last saw the deceased alive on July 21, 1959 , and that death occurred at 12:30 AM , from the causes and on the date stated above.									ADDRESS (Street, city or town, state) 4 W 3rd Street Frederick	DATE SIGNED 7-29-59	
ACTUAL SIGNATURE Thomas E. Stone		M.D.									
PHYSICIAN'S NAME (Type) Thomas E. STONE		4 West 3rd Street Frederick, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope Cemetery		22d. LOCATION (City, town, or county) Woodsboro, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert Shadley Jr.		ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR AUG 3 '59		24b. REGISTRAR'S SIGNATURE Oliver S. Krause					

CERTIFICATE OF DEATH

268

DECEASED PERSON'S NAME John Doe, Jr.	SEX Male	AGE 65 years	CAUSE OF DEATH Natural causes
ADDRESS 123 Main Street	STREET NUMBER 123	CITY Baltimore	STATE Maryland
NAME AND ADDRESS OF FUNERAL DIRECTOR John Doe, Jr., 123 Main Street, Baltimore, Maryland	DATE OF DEATH October 10, 2000		
I declare under penalty of perjury that the information contained in this certificate is true and correct.			
John Doe, Jr.			
Signature			
Date: October 10, 2000			
Place: 123 Main Street, Baltimore, Maryland			
Title: Funeral Director			
Signature		Signature	
Date: October 10, 2000		Date: October 10, 2000	
Place: 123 Main Street, Baltimore, Maryland			
Title: Funeral Director			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07969

7922

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL may be retained by one hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick-Rural RD#6				
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS Near Jug Bridge		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First AUBREY	Middle GAFFNEY	Last DAVIS	4. DATE OF DEATH	Month July	Day 10	Year 1959
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 23 March 1895	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert Lee Davis				14. MOTHER'S MAIDEN NAME Cora Layton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 271-28-6002		17. INFORMANT Mrs. Ursula B. Davis (Same as item #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Pulmonary hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bronchogenic carcinoma</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bronchial asthma</i>								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick, Md.	(County)	(State)	
21. I certify that I attended the deceased from <i>July 10, 1959</i> , to <i>July 10, 1959</i> , that I last saw the deceased alive on <i>July 10, 1959</i> , and that death occurred at <i>5:20 P.M.</i> from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 4 E. Church St.							DATE SIGNED 13 July 1959	
ACTUAL SIGNATURE <i>Henry V. Chase</i>		M.D.						
PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.		Frederick, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-13-59		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.				ADDRESS		24a. REC'D BY REGISTRAR JUL 14 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Chase</i>	

STATE OF CALIFORNIA - DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD J. HANNAH	65	M	HEART DISEASE
ADDRESS	STREET	CITY	STATE
1015 1/2 10TH	ST.	LOS ANGELES	CA
NAME AND ADDRESS OF PHYSICIAN	NAME AND ADDRESS OF FUNERAL DIRECTOR		
DR. RICHARD L. COOPER 1015 1/2 10TH ST. LOS ANGELES, CA 90015	WILLIAM J. MCGOWAN 1015 1/2 10TH ST. LOS ANGELES, CA 90015		
NAME OF PERSON FILING THIS CERTIFICATE	RELATIONSHIP TO DECEASED		
JOHN HANNAH	FATHER		
PHONE NUMBER	TELEGRAM TO		
505-1234	LOS ANGELES TIMES		
DATE OF DEATH	TIME OF DEATH		
NOVEMBER 10, 1985	10:30 AM		
TIME OF ISSUANCE	DATE ISSUED		
NOVEMBER 10, 1985	NOVEMBER 10, 1985		
APPROVED	SUPERVISOR		
JOHN HANNAH	JOHN HANNAH		
PRINTED NAME	PRINTED NAME		
JOHN HANNAH	JOHN HANNAH		

TO HOSPITAL
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7954 CERTIFICATE OF DEATH

Reg. Dist. No.

07910

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSBORO		c. LENGTH OF STAY IN lb YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X WOODSBORO		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First PAUL	Middle HARRY	Last DOUGLAS	4. DATE OF DEATH	Month JULY	Day 17	Year 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV 20, 1897	9. AGE (In years lost birthday) 61 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY STORE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY DOUGLAS		14. MOTHER'S MAIDEN NAME CLARA KREBS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 121-03-5792		17. INFORMANT MARTHA DOUGLAS		Address WOODSBORO MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia DUE TO 420.0 INTERVAL BETWEEN ONSET AND DEATH 3 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO 2 yrs + (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 17, 1959 , to July 17, 1959 , that I last saw the deceased alive on July 17, 1959 , and that death occurred at 5009 M. from the causes and on the date stated above. ACTUAL SIGNATURE B. O. Thomas M.D. ADDRESS (Street, city or town, state) Frederick, Md DATE SIGNED July 17, 1959							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/20/1959		22c. NAME OF CEMETERY OR CREMATORIAL MT HOPE		22d. LOCATION (City, town, or county) WOODSBORO (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE POWELL & HARTZLER		ADDRESS WOODSBORO MD		24a. REC'D BY REGISTRAR JUL 21 '59		24b. REGISTRAR'S SIGNATURE Clarence S. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

FAX

EMAIL

SSN

MRN

ID#

LIC#

PCP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

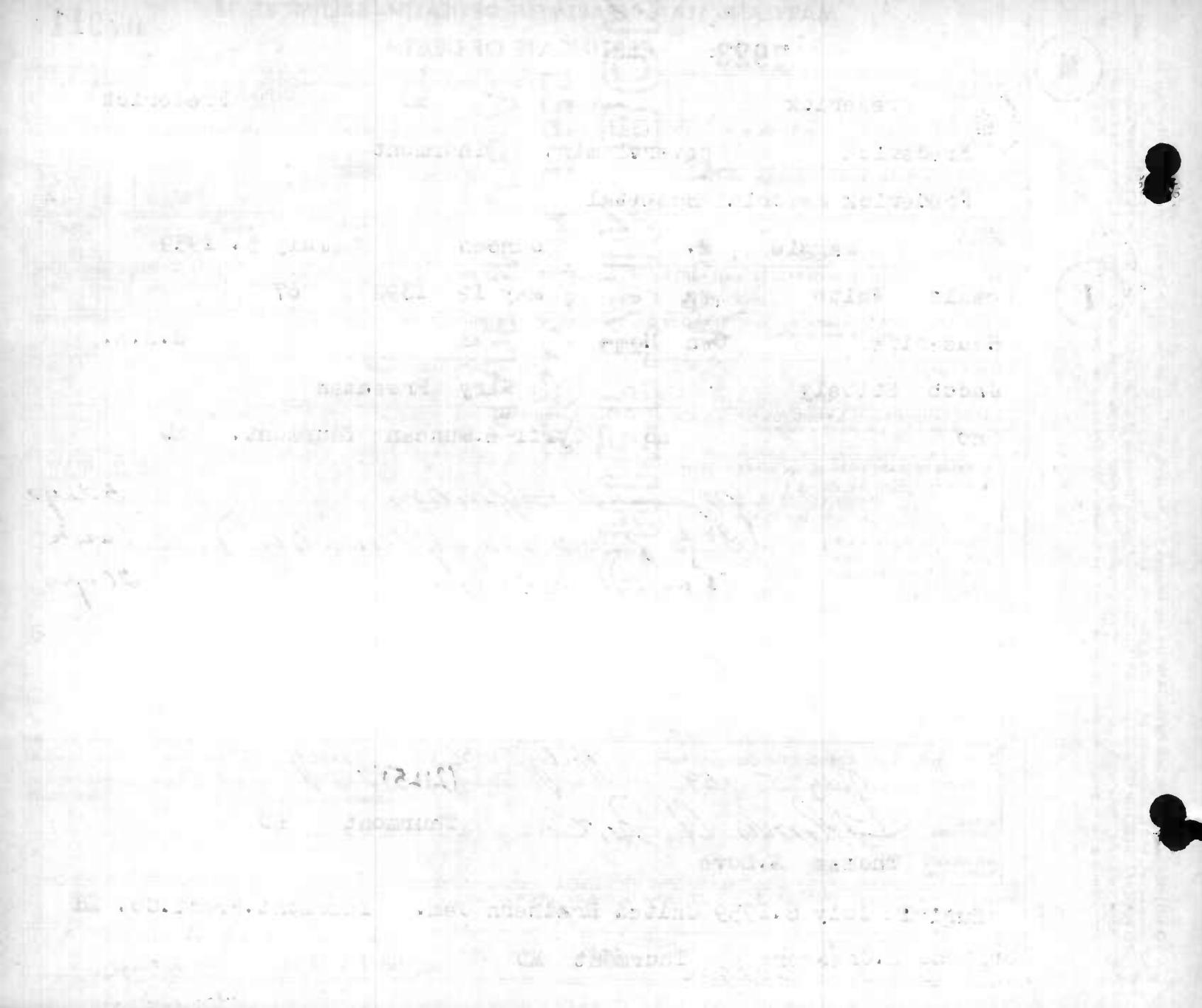
07911

7923

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b several min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Maggie	Middle M.	Last Duncan
4. DATE OF DEATH July 5. 1959	Month July	Day 5	Year 1959
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 12 1892
8. AGE (In years last birthday) 67	9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Stitely		14. MOTHER'S MAIDEN NAME Mary Freshman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Cyril E. Duncan		Address Thurmont. MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.1 DUE TO <i>Hypertensive Infarction</i>			
Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) <i>(20 to pneumonia left lower lobe)</i>			
DUE TO (c) <i>Chronic HTASCVD</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>X</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>July 5. 1959</i> to <i>July 5. 1959</i> , that I last saw the deceased alive on <i>July 5. 1959</i> , and that death occurred at <i>Thurmont</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas A. Love</i>		ADDRESS (Street, city or town, state) Thurmont MD	
PHYSICIAN'S NAME (Type) Thomas A. Love		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Safely) Burial	22b. DATE THEREOF July 8. 1959	22c. NAME OF CEMETERY OR CREMATORIUM United Brethren Cem.	22d. LOCATION (City, town, or county) Thurmont, Fred. Co. Md
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager	ADDRESS Thurmont MD	24a. REC'D BY REGISTRAR DATE JUL 10 '59	24b. REGISTRAR'S SIGNATURE <i>Elvina S. Tracy</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7924 CERTIFICATE OF DEATH

07912

Reg. Dist. No.

TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 7/3/59		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick-Rural RD#3				
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				e. STREET ADDRESS Walter Martz Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WILLIAM CORNELIUS FEAGA		First	Middle	Last	4. DATE OF DEATH July 16, 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Oct 1892		9. AGE (In years (on birthday) 66 yrs.)	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Elmer B. Feaga		14. MOTHER'S MAIDEN NAME Orsena Staley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 203X		16. SOCIAL SECURITY NO. 220-34-2325		17. INFORMANT Mrs. Blanche Feaga (Same as item #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma		DUE TO				INTERVAL BETWEEN ONSET AND DEATH Month		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 203X		(b) DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick, Md.	(County) Frederick County	(State) Maryland	
21. I certify that I attended the deceased from alive on		7/16, 1959		7/16, 1959 , to		7/16, 1959 , that I last saw the deceased from the causes and on the date stated above.		
ACTUAL SIGNATURE James B. Thomas		M.D.		ADDRESS (Street, city or town, state) 228 N. Market St.		DATE SIGNED 17 July 1959		
PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		Frederick, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-59		22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Hill Cemetery		22d. LOCATION (City, town, or county) Frederick County Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Jul 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

TO HOSPITAL: The hospital or attending physician may be retained.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7955

CERTIFICATE OF DEATH

107913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg.		c. LENGTH OF STAY IN lb 12 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Emmitsburg,		d. STREET ADDRESS 301 West Main	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gettysburg Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lula	Middle May	Last Fitez	4. DATE OF DEATH Month July	Month 30,	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1892	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months 67	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Adams Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Bollinger		14. MOTHER'S MAIDEN NAME Alice Herr					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT W.R. Fitez			Address 301 West Main St. Emmitsburg, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular disease DUE TO 420.1 INTERVAL BETWEEN ONSET AND DEATH Hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic disease (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month July	Day 30	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Emmitsburg	(County) (State) Emmitsburg, Md.
21. I certify that I attended the deceased from July 30, 1959 , to July 30, 1959 , that I last saw the deceased alive on July 30, 1959 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE W.R. Cadle ADDRESS (Street, city or town, state) Emmitsburg, Md. DATE SIGNED 7-31-59							
PHYSICIAN'S NAME (Type) Dr. W. R. Cadle		Emmitsburg, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 3, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Mt. View		22d. LOCATION (City, town, or county) Emmitsburg, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR DATE AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	
C. E. Wilson							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7956 CERTIFICATE OF DEATH

Reg. Dist. No.

117914

TO HOSPITAL _____ may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick				a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b 109 days		b. COUNTY	
Cullen					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Victor Cullen State Hospital		Baltimore City		3 V O I - 4	
d. STREET ADDRESS		f. IS RESIDENCE ON A FARM?			
no definite address		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Philip				Frank	7 9 1959
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1900	9. AGE (In years lost birthday) yrs. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (State or foreign country) La	
12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Philip Frank		14. MOTHER'S MAIDEN NAME Benah Ray			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 055-12-7024		17. INFORMANT Records of Victor Cullen Hospital Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from olive on 7/9 1959		12/22 1959 to 7/9 1959		that I last saw the deceased on 7/9 1959, and that death occurred at Thurmont, Maryland, from the causes and on the date stated above.	
ACTUAL SIGNATURE T.F. Reddall		M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)		Cullen, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-13-59		22c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cemetery	
22d. LOCATION (City, town, or county) Thurmont, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Cullen		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR JUL 14 '59	
				24b. REGISTRAR'S SIGNATURE Charles S. Pearce	

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

1990

1990



TO HOSPITAL may be retained
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7957

CERTIFICATE OF DEATH

07915

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First ETHEL	Middle VIOLA	Last FRENCH	4. DATE OF DEATH	Month July	Day 7	Year 1959
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S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 19 Oct 1885	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME John Anderson	14. MOTHER'S MAIDEN NAME Elizabeth Baker
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT James M. French (Same as item #1)	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		<i>Gastric Carcinomatosis</i> <i>Carcinoma Large Bowel</i> 7 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Dec 3, 1958</u> , to <u>July 7, 1959</u> , that I last saw the deceased alive on <u>July 7, 1959</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above.			ADDRESS (Street, city or town, state) 4 E. Church St.	DATE SIGNED 8 July 1959
ACTUAL SIGNATURE <i>E.P. Thomas</i>	M.D.			

PHYSICIAN'S NAME (Type) E. P. Thomas, M. D.	Frederick, Md.
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-9-59	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery	22d. LOCATION (City, town, or county) (State) Point of Rocks, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 13 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7925

CERTIFICATE OF DEATH

Reg. Dist. No.

07916

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Leonard	Middle Ivan	Last Giffit	4. DATE OF DEATH	Month 7	Day 6	Year 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-1-1904	9. AGE (In years (last birthday) yrs. 55	10. UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY road construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Mayberry Giffit				14. MOTHER'S MAIDEN NAME Martha Holmes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Ray Giffit, Burkittsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Coronary Occlusion & Edema 5 1/2 hrs Coronary Sclerosis 3 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/6/59 to 7/6/59 , that I last saw the deceased alive on 7/6/59 , and that death occurred at Jefferson, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jefferson DATE SIGNED 7/6/59							
ACTUAL SIGNATURE Dr. A. Talbott Brice		M.D.					
PHYSICIAN'S NAME (Type) Dr. A. Talbott Brice		Jefferson, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/9/1959		22c. NAME OF CEMETERY OR CREMATORIUM Samples Manor Cemetery		22d. LOCATION (City, town, or county) (State) Washington Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 13 '59		24b. REGISTRAR'S SIGNATURE James S. Martin	

TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07917

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Luther Martin		First	Middle	Last	4. DATE OF DEATH Gilbert	Month 7	Day 1	Year 19 59
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/1901	9. AGE (In years lost birthday) yrs. 57	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Doys 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machine operator		10b. KIND OF BUSINESS OR INDUSTRY brush factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Jasper Gilbert		14. MOTHER'S MAIDEN NAME Dessie Summers						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-12-2819		17. INFORMANT Mrs. Grace Dutrow, Frederick, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease, with acute myocardial infarction 10 years DUE TO Conditions, if any, which gave rise to immediate cause (a), slating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Sudden INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	Day	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 35 E. Church	(County) Middleton	(State) Md.	
21. I certify that I attended the deceased from 1-1 , 19 59 , to 7-1- , 19 59 , that I last saw the deceased alive on 4-2 , 19 59 , and that death occurred at M. , from the causes and on the date stated above. ACTUAL SIGNATURE Rex R. Martin M.D. 35 E. Church Frederick Md 7-1-59 ADDRESS (Street, city or town, state) DATE SIGNED								
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/4/1959	22c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery		22d. LOCATION (City, town, or county) Middletown, Md.			(State)
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 7 59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7927

CERTIFICATE OF DEATH

Reg. Dist. No.

07918

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1205 N. Market St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ethel	Middle	Last Gladhill	4. DATE OF DEATH Month 7	Day 17	Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/4/1878	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles C. Coblenz			14. MOTHER'S MAIDEN NAME Emma F. Ropp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Charles Cline, Frederick, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Carcinoma of Stomach INTERVAL BETWEEN ONSET AND DEATH 2 years?						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 14 16 , 1959, to July 17 , 1959, that I last saw the deceased alive on July 16 , 1959, and that death occurred at 8:30 p.m. from the causes and on the date stated above.						
ACTUAL SIGNATURE L.R. Schoolman		ADDRESS (Street, city or town, state) 225 N Market St Frederick 7/18/59				
DATE SIGNED 7/18/59						
PHYSICIAN'S NAME (Type) Dr. L.R. Schoolman						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 7/20/1959	22c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery			22d. LOCATION (City, town, or county) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.			ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 21 '59		
				24b. REGISTRAR'S SIGNATURE Arthus S. Kraus		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7958

CERTIFICATE OF DEATH

Reg. Dist. No.

117919

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Rural Thurmont		50 yrs		X Rural Thurmont				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year
Stephen Allen Green					July	18, 1959	19	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years 73 birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
Male White				June 1 1886	73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Timberman			Self employed		Frederick Co. MD			U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME					
Jacob Green			Isabelle Hancock					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		INFORMANT		Address	
No			No		Mrs Olive M. Green. Thurmont		MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart disease Chr. Valvular type</i> DUE TO <i>421.4</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>July</i> , 19 <i>59</i> to <i>July 1—1959</i> that I last saw the deceased alive on <i>July 1—1959</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>James K. Gray</i> ADDRESS (Street, city or town, state) <i>Thurmont - Md.</i> DATE SIGNED								
PHYSICIAN'S NAME (Type) <i>James K. Gray</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		
Burial		July 21, 1959		Mt. Bethel Methodist Cem.		Nr. Garfield Fredk. Co. Md		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
<i>Raymond E. Creager</i>		Thurmont		JUL 22 '59		<i>C. L. & K. Hause</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7928

CERTIFICATE OF DEATH

Reg. Dist. No.

117920

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 25 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 109 West Second St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Wilbur	Middle Foard	Last Hammaker	4. DATE OF DEATH Month July	Day 29th	Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 27-1888	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Memorial Dealer		10b. KIND OF BUSINESS OR INDUSTRY Monument Works		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjamin Franklin Hammaker				14. MOTHER'S MAIDEN NAME Martha Virginia Ensor				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-20-9483		17. INFORMANT Mrs. Wilbur F. Hammaker-109 W. 2nd. St. Md.		Address Frederick-		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Paralysis Agitans - 2 yrs.								
INTERVAL BETWEEN ONSET AND DEATH 10 days								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Paralysis Agitans - 2 yrs.						
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Maryland	(State) Md.
21. I certify that I attended the deceased from July 1, 1959 to July 29, 1959 , that I last saw the deceased alive on July 29, 1959 , and that death occurred at 6:05 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 4 East Church Street								
ACTUAL SIGNATURE A. A. Pearce M.D.								
DATE SIGNED 7/31/59								
PHYSICIAN'S NAME (Type) Dr. A. A. Pearce		Frederick- Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-1959		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick- Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Dailys Funeral Home		ADDRESS Frederick- Md.		24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
VS A15 (4) 15M 9/55		DATE AUG 3 '59						

— 1 —

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07921

7959 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Myersville		c. LENGTH OF STAY IN 1b 21 years		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Myersville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1				d. STREET ADDRESS Route # 1					
3. NAME OF DECEASED (Type or print)		First MAE	Middle M.	Lost HARP	4. DATE OF DEATH	Month July	Day 7	Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 18, 1885		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Junita Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME A. M. Bryner				14. MOTHER'S MAIDEN NAME Elizabeth Swartz					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT Upton V. Harp, Myersville, Md. Rt. # 1		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Middleton	(County) Middle	(State) Md.	
21. I certify that I attended the deceased from July 7, 1959 , to July 7, 1959 , that I last saw the deceased alive on July 7, 1959 , and that death occurred at Middleton , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Middleton	DATE SIGNED July 8 59
ACTUAL SIGNATURE <i>J. Elmer Harp</i>		PHYSICIAN'S NAME (Type) J. Elmer Harp		Middletown, Md.					
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Grossnickle's		22d. LOCATION (City, town, or county) (State) Nr. Myersville, Fred. Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul F. Bittle</i>				ADDRESS Paul F. Bittle, Myersville, Md.		24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE	
						DATE JUL 10 '59			

CERTIFICATE OF DEATH

Date of Birth

Date of Death

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Doctor

Signature

Signature



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

117922

7929 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A1S (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE PENN.		b. COUNTY JUNIATA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b OCT. 18, 1958		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MEALISTERVILLE 75X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		e. STREET ADDRESS none		d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle LELA	Last HEADINGS	4. DATE OF DEATH JULY 20, 1959	Month JULY	Day 20	Year 1959
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-9-74	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 85	IF UNDER 24 HRS. Days 85	Year Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MOORE		14. MOTHER'S MAIDEN NAME ELIZABETH KELLY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Mildred J. Headings		Address 1201 Beechwood, Frederick, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) CARCINOMA OF BLADDER DUE TO (c) CEREBRAL THROMBOSIS							
INTERVAL BETWEEN ONSET AND DEATH 1956-57							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1) Diabetes Mellitus, 2) Generalized Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 Feb. 1957 to 20 July 1957 that I last saw the deceased alive on 20 July 1957 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) SHOPPING CENTER, FREDERICK, MD.							
DATE SIGNED 7-20-59							
ACTUAL SIGNATURE Robert D. Crouch		M.D.					
PHYSICIAN'S NAME (Type) ROBERT D. CROUCH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Lost Creek Presbyterian Cem., Juniata County,		22d. LOCATION (City, town, or county) (State) Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 21 '59	24b. REGISTRAR'S SIGNATURE C. L. & K. Hause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7960

CERTIFICATE OF DEATH

17923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE		First EUGENE	Middle HEMP
4. DATE OF DEATH Month July	Day 18,	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1898
9. AGE (In years from birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner and Live Stock Dealer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence E. Hemp		14. MOTHER'S MAIDEN NAME Julia Elgin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Mrs. Helen R. Hemp-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1/2 M			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I attended the deceased from 7-16-1959 to 7-16-1959 that I last saw the deceased alive on 7-16-1959 , and that death occurred at 7:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 Petersville Road			
ACTUAL SIGNATURE <i>C. E. Pruitt, M.D.</i>		DATE SIGNED 7/20/59	
PHYSICIAN'S NAME (Type) C. E. Pruitt, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 21, 1959	22c. NAME OF CEMETERY OR CREMATORIUM St. Mark's Cemetery
22d. LOCATION (City, town, or county) Frederick County, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JUL 22 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

117924

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7930 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Frederick MARYLAND		Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Years	
Frederick		11 Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
830 Trail Avenue		830 Trail Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First PAUL	Middle EDWIN
		Last HOUCK	4. DATE OF DEATH
			Month July Day 24, Year 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		White	B. DATE OF BIRTH November 25, 1899
8. AGE (In years at birth) 59 yrs.		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooler Operator		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel E. Houck		14. MOTHER'S MAIDEN NAME Susie E. Kreglo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-22-2063	
		17. INFORMANT Mrs. Mabel B. Houck—Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		GUN SHOT WOUND OF CHEST AND HEART	
976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Instant	
(b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot Self with shot gun	
20c. TIME OF INJURY Hour 8:15 AM 7/24/1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At Home		20f. (City or town) Frederick, Frederick, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED 7/25/59	
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Prospect Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederik, Maryland		24a. REC'D BY REGISTRAR DATE JUL 27 '59	
		24b. REGISTRAR'S SIGNATURE <i>Curious L. Krause</i>	
VS. ATMS(E) SM 9/55			

TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burier-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7931

CERTIFICATE OF DEATH

Reg. Dist. No.

07925

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Day 11	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle JOSEPH	4. DATE OF DEATH Month July Day 8, Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY RailRoad	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Joseph F. Houff		14. MOTHER'S MAIDEN NAME Mary Ida Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 705-09-2826	17. INFORMANT Address Mrs. Julia E. Houff- Same as item #2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis INTERVAL BETWEEN ONSET AND DEATH 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Ruptured Sigmoid colon 26 hrs { DUE TO (c) Carcinoma of rectum & obstruction			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I attended the deceased from 7 July , 1959, to 8 July , 1959, that I last saw the deceased alive on 8 July , 1959, and that death occurred at 12:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 7/9/59			
ACTUAL SIGNATURE <i>Melvin E. Lea</i>	M.D. Frederick, Maryland		
PHYSICIAN'S NAME (Type) Melvin E. Lea, M.D.		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 11, 1959	22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JUL 13 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>

DEPARTMENT OF DEFENSE
CERTIFICATE OF DESIGN

STATE OF CALIFORNIA

1962

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07926

CERTIFICATE OF DEATH

Reg. Dist. No.

7932

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Liberty		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Howard	Middle Daniel	Last Kefauver	4. DATE OF DEATH	Month 7	Day 19	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1/12/1879	9. AGE (in years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Lewis Franklin Kefauver				14. MOTHER'S MAIDEN NAME Virginia Cookerly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. John M. Carter, Liberty	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus INTERVAL BETWEEN ONSET AND DEATH 5 min 466X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Phlebitis thrombosis pelvic veins (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Past ap from Gastrectomy for chronic duodenal ulcer							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) IF EITHER, NOTIFY MEDICAL EXAMINER		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
Hour o. m. p. m.		While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
19							
21. I certify that I attended the deceased from 7 July , 1959, to 19 July , 1959, that I last saw the deceased alive on 18 July , 1959, and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Melvin E. Lea				ADDRESS (Street, city or town, state) 35 E Church St			
PHYSICIAN'S NAME (Type) Melvin E. Lea MD				DATE SIGNED 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 21, 1959	22c. NAME OF CEMETERY OR CREMATORIALy Liberty Fairmount Cemetery	22d. LOCATION (City, town, or county) Liberty, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co. ,	ADDRESS Middletown, Maryland	24a. REC'D BY REGISTRAR Arthur S. Krause	24b. REGISTRAR'S SIGNATURE				

TO HOSPITAL
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE DOCUMENTS HELD IN EVIDENCE 18

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7961 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07927

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certifying officer by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		d. STREET ADDRESS						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)												
3. NAME OF DECEASED (Type or print) Harry		First	Middle	Last	4. DATE OF DEATH C. Keller	Month	Day	Year				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/1887	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mason, ret.		10b. KIND OF BUSINESS OR INDUSTRY building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.						
13. FATHER'S NAME Daniel Rupley Keller		14. MOTHER'S MAIDEN NAME Jeannetta Routzahn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-16-0769			17. INFORMANT Mrs. Robert Haupt, Middletown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) fractured skull and drowning		DUE TO							INTERVAL BETWEEN ONSET AND DEATH minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 823 X		(b)										
DUE TO		(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) automobile accident - car plunged off Hollow road into a stream		20c. TIME OF INJURY Month, Day, Year Hour a. m. X 12 - p.m. 7/17/ 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) county road		20f. (City or town) Rural Middletown, Fred	(County) Md.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/17/59				
EXAMINER'S NAME (Type) Dr. B. O. Thomas												
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/20/1959		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Myersville, Md.		(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause						

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17928

7933 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		d. STREET ADDRESS 6810 Beech Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 N. Market St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Daisy	Middle C.	Last Killian	4. DATE OF DEATH July 12 1959	Month July	Day 12	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1877	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown Kilian		14. MOTHER'S MAIDEN NAME Daisy C. Fox					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Doris Everding		Address 4813 Herring Run Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 3 weeks							
443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-vascular disease 5 years. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5, 1955 , to July 12, 1959 , that I last saw the deceased alive on July 11, 1959 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Frederick, Md.					
ACTUAL SIGNATURE Bernard O. Thomas Jr. M.D.		DATE SIGNED July 12, 1959					
PHYSICIAN'S NAME (Type) B. O. Thomas Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE JUL 14 '59		24b. REGISTRAR'S SIGNATURE Orilia S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7934 CERTIFICATE OF DEATH

Reg. Dist. No.

17929

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 12-23-58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (24)		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Odd Fellows Home				d. STREET ADDRESS 3712 Hudson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARMILLIA		First MAY	Middle LAST	4. DATE OF DEATH July 16,	Month Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 27 May 1880	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Millard F. Morrison		14. MOTHER'S MAIDEN NAME Alice Maria O'Dell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Odd Fellows Home Records (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		CORONARY OCCLUSION				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		CHRONIC MYOCARDITIS				10 Yrs. (?)	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on July 15, 1959		July 2, 1959		to July 16, 1959		that death occurred at 4:30 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>W. M. Smith</i>				M.D.		ADDRESS (Street, city or town, state) 4 E. Church St.	
PHYSICIAN'S NAME (Type) William M. Smith, M. D.		Frederick, Md.				DATE SIGNED 17 July 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 21 '59		24b. REGISTRAR'S SIGNATURE <i>Cather S. Kraus</i>	

TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE OF MARYLAND—BALTIMORE CITY

CERTIFICATE OF DEATH

DECEASED PERSON	NAME	AGE	SEX	CAUSE OF DEATH	TIME OF DEATH	PLACE OF DEATH	NAME OF DOCTOR	ADDRESS
John Doe	Male	50	White	Heart Disease	10:00 AM	Hospital	Dr. John Smith	123 Main Street
This certificate is issued under the laws of Maryland.								
Baltimore City Health Department								

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G244 7/10/59 cap

7935

CERTIFICATE OF DEATH

Reg. Dist. No.

07930

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 days years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rt. #2, Frederick, Maryland		d. STREET ADDRESS Rt. # 2 Frederick, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle E.	Last Marino	4. DATE OF DEATH July 1, 1959	Month July	Day 1	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH December 11, 1902	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months 57	IF UNDER 24 HRS. Days 56	Hours hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Part owner of restaurant and taveran		10b. KIND OF BUSINESS OR INDUSTRY Washington D.C.		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Marino				14. MOTHER'S MAIDEN NAME Lucy Lion			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-12-2057		17. INFORMANT Miss Rose Marino (Sister) Rt. # 2 Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 572.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO TO adhesions from diverticula							
INTERVAL BETWEEN ONSET AND DEATH 4 days							
DUE TO (c) TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-30 , 1959, to 7-1- , 1959, that I last saw the deceased alive on 6-30 - 1959 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Rex R Martin</i>		M.D.					
PHYSICIAN'S NAME (Type) Dr. Rex Martin		M.D. 35 East Church Street Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4, 1959		22c. NAME OF CEMETERY OR CREMATORIUM St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Dailey Jr.</i>		ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	

CERTIFICATE OF DEATH

1392

DEATH CERTIFICATE NO.	NAME OF DECEASED	SEX	AGE	CAUSE OF DEATH
1392	JOHN J. DUNN	M	65	CHRONIC CARDIOPNEUMONIC HEART DISEASE
ADDRESS		CITY, STATE, ZIP CODE		
1315 1/2 16TH AVENUE SAN FRANCISCO, CALIFORNIA 94103		SAN FRANCISCO, CALIFORNIA 94103		
BORN		DIED		TIME
NOV. 11, 1896		NOV. 2, 1961		10:00 A.M.
MATERIAL TESTED		TESTS		
0.6 mg/dl blood		REMOVED FOR DETERMINATION OF CAUSE OF DEATH		
TOOK		ON THE FOLLOWING		
NOVEMBER 11, 1961 (ADMITTED)		NOVEMBER 11, 1961		
BY		DOCTOR		
DR. RICHARD L. HARRIS		HOSPITAL		
SAN FRANCISCO GENERAL HOSPITAL		SAN FRANCISCO, CALIFORNIA		
REASON FOR EXAMINATION		DEATH CERTIFICATE		
DEATH CERTIFIED		EXAMINER'S SIGNATURE		
NOVEMBER 11, 1961		RICHARD L. HARRIS		
BY		HOSPITAL		
SAN FRANCISCO GENERAL HOSPITAL		SAN FRANCISCO, CALIFORNIA		
REASON FOR EXAMINATION		DEATH CERTIFICATE		
NOVEMBER 11, 1961		RICHARD L. HARRIS		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

VS. AISM(E) 5
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7936 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07931

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 201 Grove Boulevard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First David	Middle John	Lost Markey Jr.	4. DATE OF DEATH July	Month 5	Day 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1909	9. AGE (in years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 50		IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Editor		10b. KIND OF BUSINESS OR INDUSTRY News Paper		11. BIRTHPLACE (State or foreign country) Frederick		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME D. John Markey				14. MOTHER'S MAIDEN NAME Edna Mullinix			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-3208		17. INFORMANT Mrs Alice Markey, Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct INTERVAL BETWEEN ONSET AND DEATH 4 days							
DUE TO Conditions, if any, which gave rise to immediate cause (b)							
DUE TO (c), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O.Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 5, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 7 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Knoll

181-90

01 BROWNSVILLE TO THE STATE OF TEXAS
MIA TO STADFLIRG 20MMAG3 JACKSON 803



1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a telegram, giving the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, forwarded to the Chief Medical Examiner's Office along with form PM43. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17932

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick MARYLAND		a. STATE Maryland	b. COUNTY Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Frederick		Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Frederick	
402 West Second Street		d. STREET ADDRESS	
402 West Second		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Arthur	Middle Thomas	Last McCanner
4. DATE OF DEATH	Month July	Day 4	Year 1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feburary 25 1893 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Merchant		Merchant	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Frederick		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Owen McCanner		Alla Kline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		214-10-1298	
17. INFORMANT		Address	
James McCanner Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH			
420.1 DUE TO 5 minute			
Conditions, if any, which gave rise to immediate cause (b)			
(a), stating the underlying cause last. DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE	DATE SIGNED		
B.O. Thomas, M.D.			
EXAMINER'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 7, 1959	22c. NAME OF CEMETERY OR CREMATORI Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR JUL 7 59	24b. REGISTRAR'S SIGNATURE
Robert E. Taylor		Frederick, Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

117933

7938

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN lb 58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNIE BELLE A. MEASELL		First	Middle
		Lust	4. DATE OF DEATH JULY 1 1959
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH OCT 7 1881		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCERY		10b. KIND OF BUSINESS OR INDUSTRY GROCERY	
11. BIRTHPLACE (State or foreign country) M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE A. ALEXANDER		14. MOTHER'S MAIDEN NAME MARY ELIZABETH TRACEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-30-98523	
17. INFORMANT EDNA MEASELL		Address FREDERICK MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 331X			
(b) Arterio'sclerosis			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio clorotic Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 11, 1959 to July 1, 1959 , that I last saw the deceased alive on July 1, 1959 , and that death occurred at 30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) FREDERICK, MD			
ACTUAL SIGNATURE D. A. Pearce		DATE SIGNED 7/2/59	
PHYSICIAN'S NAME (Type) Clarence L. County, Frederick, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL July 3, 1959		22b. DATE THEREOF July 3, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET		22d. LOCATION (City, town, or county) (State) FREDERICK MD	
23. FUNERAL DIRECTOR'S SIGNATURE Elaine C. County, Frederick, Md		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
		24b. REGISTRAR'S SIGNATURE John S. Trahan	

TO HOSPITAL or attending physician: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										117934
7939 CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN lb 46 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					
d. NAME OF HOSPITAL (If not in hospital, give street address) <small>FOR INSTITUTION</small> Frederick Memorial Hospital					d. STREET ADDRESS 256 West Patrick Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First ADA	Middle CATHERINE	Last MICHAEL	4. DATE OF DEATH	Month July	Day 7,	Year 1959		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 25 Jan 1885	9. AGE (In years at birthday) 74 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Eugene Etchison					14. MOTHER'S MAIDEN NAME Emma Steiner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. <small>(If yes, give war or dates of service)</small> None		17. INFORMANT Stanley A. Michael (Same as item #2)			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <small>ADDRESS (Street, city or town, state)</small>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick, Md. (County) Maryland (State)			
21. I certify that I attended the deceased from Feb , 1955 to July 7 , 1959, that I last saw the deceased alive on July 7 , 1959, and that death occurred at 5:40A M, from the causes and on the date stated above. <small>ADDRESS (Street, city or town, state)</small> <small>DATE SIGNED</small>										
ACTUAL SIGNATURE Henry V. Chase M.D. 4 E. Church St. 8 July 1959										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 7-10-59		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery			22d. LOCATION (City, town, or county) <small>(State)</small> Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland					ADDRESS		24a. REC'D BY REGISTRAR <small>DATE</small>	24b. REGISTRAR'S SIGNATURE <small>DATE</small>		
							JUL 13 '59			
							Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7962 CERTIFICATE OF DEATH

Reg. Dist. No. 117933

07935

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE					
<u>Frederick</u>		MARYLAND <u>Maryland</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Frederick</u>	c. LENGTH OF STAY IN 1b <u>5 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont, Md.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick County Chronic Hospital</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	d. STREET ADDRESS <u>Altamont Ave.</u>					
3. NAME OF DECEASED (Type or print)	First <u>Emma</u>	Middle <u>Rebecca</u>	Last <u>Miller</u>				
4. DATE OF DEATH	Month <u>7</u>	Day <u>28</u>	Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5/21/77</u>	9. AGE (In years last birthday) <u>82 yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Mr. Jacob Baumgardner</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Mc Hally</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	17. INFORMANT <u>Ruth Crawford, sp. Fred. County Chronic</u>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>260X</u>		Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH <u>13 yrs.</u>			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) <u></u>		Arterio Sclerosis		10 yrs.			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Frederick</u>	(County) <u>Frederick Co.</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>July 24, 1959</u> to <u>July 28, 1959</u> , that I last saw the deceased alive on <u>July 27, 1959</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Frederick, Md.</u> DATE SIGNED <u>July 28, 1959</u>					
ACTUAL SIGNATURE <u>H. F. Kline</u>		M.D.					
PHYSICIAN'S NAME (Type) <u>H. F. KLINE</u>		Frederick					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-30-59</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Kriders Cemetery</u>		22d. LOCATION (City, town, or county) <u>Westminster</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		ADDRESS <u>Thurmont, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. Hall & Sons</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7940

CERTIFICATE OF DEATH

Reg. Dist. No.

107936

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY <i>Fred</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS PARK AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HARRY	Middle WALTER	Last MILLER	4. DATE OF DEATH Month July	Month 21	Day 1959	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 19, 1886	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months 12	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barbering		11. BIRTHPLACE (State or foreign country) Frederick Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Franklin P. Miller				14. MOTHER'S MAIDEN NAME Cora Cramer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. 217-32-5131		17. INFORMANT Daughter Mrs. Edward Silance, Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectosigmoid. INTERVAL BETWEEN ONSET AND DEATH 1 yr							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 1. Cardio-vascular collapse 2. Post-op. wound dehiscence							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 13 July , 1959, to 21 July , 1959, that I last saw the deceased alive on 21 July , 1959, and that death occurred at 5:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Melvin E. Lea</i> M.D.						ADDRESS (Street, city or town, state) 35, East Church St.	
PHYSICIAN'S NAME (Type) Melvin E. Lea, MD.		DATE SIGNED 7/22/59					
22a. BURIAL, CREMATION, BURIAL BURIAL	22b. DATE THEREOF 7/24/59	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet		22d. LOCATION (City, town, or county) Frederick, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Dailey Jr.</i>		ADDRESS FREDERICK, Md.		24a. REC'D BY REGISTRAR DATE JUL 27 '59		24b. REGISTRAR'S SIGNATURE <i>John J. Frank</i>	

MAY 1948 STATE DEPARTMENT OF HEALTH - BUREAU OF

CERTIFICATE OF DEATH

NAME

NAME

NAME

NAME

NAME

NAME

DEATH DATE

Death of Edward J. O'Leary

AGE

AGE

AGE

AGE

AGE

* ADDRESS

ADDRESS

ADDRESS

ADDRESS

NAME

NAME

EDWARD J. O'LEARY DECEASED DEATH CERTIFICATE

EDWARD J. O'LEARY

EDWARD J. O'LEARY

EDWARD J. O'LEARY

EDWARD J. O'LEARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7963 CERTIFICATE OF DEATH

Reg. Dist. No.

17937

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Thurmont, Md.</i>		b. COUNTY <i>Frederick</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick, Md.</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Thurmont</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick County Chronic Hospital</i>				d. STREET ADDRESS <i>Altamont Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>William Murray Miller</i>		First	Middle	Last	4. DATE OF DEATH <i>7 27 1959</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-7-1880</i>	9. AGE (In years from last birthday) <i>79 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Mr. Edward Nelson Miller</i>		14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Lippy</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-28-0972</i>		17. INFORMANT <i>Ruth Crawford Mrs. Lippy</i>		Address		
IB. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Cerebral Hemorrhage Arterio Sclerosis						
		INTERVAL BETWEEN ONSET AND DEATH <i>2 yr.</i>						
		2 yr.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>				
21. I certify that I attended the deceased from <i>July 24, 1959</i> to <i>July 26, 1959</i> , that I last saw the deceased alive on <i>July 26, 1959</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED						
ACTUAL SIGNATURE <i>H.F. Kline</i>		M.D. <i>777 Market St. Frederick Md.</i> <i>July 21, 1959</i>						
PHYSICIAN'S NAME (Type) <i>H.F. KLINE MD.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-30-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Kriders Cemetery</i>		22d. LOCATION (City, town, or county) <i>Westminster, Md.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Creager</i>		ADDRESS <i>Thurmont, Md.</i>		24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7941

CERTIFICATE OF DEATH

17938

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Frederick</i>				a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Frederick</i>		<i>4 days</i>		<i>Westminster RD#2 06x-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		d. STREET ADDRESS	
<i>Frederick Memorial Hospital</i>				<i>Pleasant Valley</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Laura</i>	Middle <i>JANE</i>	Last <i>Myers</i>	4. DATE OF DEATH	Month <i>July</i> Day <i>7</i> Year <i>1959</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Feb. 1, 1891</i>	9. AGE (In years lost/birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>House-wife</i>		<i>—</i>		<i>Carroll Co. Md.</i>	
13. FATHER'S NAME <i>Edward German</i>		14. MOTHER'S MAIDEN NAME <i>Alberta Bankert</i>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Ray C. Smith, Walkersville, Md.</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>420.0</i>		ACUTE CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO <i>Arteriosclerotic Heart disease</i>		5 yr +	
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Diabetes mellitus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I attended the deceased from <i>7/3</i> , 19 <i>59</i> , to <i>7/7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>7/7</i> , 19 <i>59</i> , and that death occurred at <i>4 E. Church St</i> , 12 th fl., M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Henry V Chase</i>		M.D.		ADDRESS (Street, city or town, state) <i>4 E. Church St</i>	
DATE SIGNED <i>7/7/59</i>					
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>		Frederick Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/10/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Pleasant Valley Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Westminster, Md.</i>				(State) <i>RD#2</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers Jr., Westminster, Md.</i>		ADDRESS <i>J. E. Myers Jr., Westminster, Md.</i>		24a. REC'D BY REGISTRAR DATE JUL 10 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7964 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 See: Birth Cert. et

Reg. Dist. No.

07939

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a self-addressed envelope and write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY	Frederick		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Woodsboro R.D.		c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woodsboro R.D.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Daniel Michael Affitt				July	7	1959	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years at last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 18, 1950	1 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Frederick		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Bernard Affitt		Lillian Kingsbury		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT			
(If yes, give war or dates of service)				Bernard Affitt Woodsboro, Md			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull (Except region)	Minutes
835X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by Tractor	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. 7 / 7 1959 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Woodsboro, Frederick, Md		(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
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ACTUAL SIGNATURE B.O. Thomas	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED July 7, 1959		
EXAMINER'S NAME (Type) B.O. Thomas, M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 10, 1959	22b. DATE THEREOF Mt. Hope Cemetery	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ADDRESS	22d. LOCATION (City, town, or county) Woodsboro	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE G. O. Barton, Walkersville, Md.	24d. REC'D BY REGISTRAR JUL 10 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Evans		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7942

CERTIFICATE OF DEATH

Reg. Dist. No.

07940

TO HOSPITAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		d. STREET ADDRESS /		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue County Home				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Joseph		First	Middle	Last	4. DATE OF DEATH July 14, 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Calip Potts			14. MOTHER'S MAIDEN NAME Amelia Hosley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Robert Schell (Supt. of Montevue) Fred. Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral Hemorrhage								
DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Arterio Sclerosis								
INTERVAL BETWEEN ONSET AND DEATH 3 yrs.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7th		20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from July 14 , 1959, to July 14 , 1959, that I last saw the deceased alive on July 14 , 1959, and that death occurred at 10:25 PM from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 7 North Market Street, Frederick, Md.								
DATE SIGNED July 15, 1959								
ACTUAL SIGNATURE H. E. Kline								
PHYSICIAN'S NAME (Type) Dr. H. E. Kline, Sr.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-18-1959		22c. NAME OF CEMETERY OR CREMATORIUM Friendship		22d. LOCATION (City, town, or county) Montgomery Co., Maryland		
(State)								
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.								
24a. REC'D BY REGISTRAR DATE JUL 17 '59					24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

WYOMING STATE DEPARTMENT OF HEALTH - DATA CENTER

CERTIFICATE OF DATA

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7943 CERTIFICATE OF DEATH

Reg. Dist. No. 117941

TO HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 603 Rosemont Avenue					
d. NAME OF HOSPITAL (If not in hospital, give street address) 603 Rosemont Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First ANNE	Middle SOPHIA	Last SCHILDKNECHT	4. DATE OF DEATH	Month July	Day 22	Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Sept 1895	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 513	IF UNDER 24 HRS. Days 12 hr	Hours 45	Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Daniel Bentz			14. MOTHER'S MAIDEN NAME Mary A. Shipley								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT William R. Schildknecht, Frederick, Md.		513 Magnolia Ave., Frederick, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Acute pulmonary infarction DUE TO Hyperensive C. V. D. Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hr 30 years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 9/20 , 19 47 , to 7/22 , 19 59 , that I last saw the deceased alive on 7/20 , 19 59 , and that death occurred at 4:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE L. R. Schoolman		ADDRESS (Street, city or town, state) 228 N. Market St.		DATE SIGNED 23 July 1959							
PHYSICIAN'S NAME (Type) L. R. Schoolman, M. D.		Frederick, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-25-59		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)					
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS M. R. Etchison & Son, Frederick, Maryland		24a. REC'D. BY REGISTRAR JUL 27 1959		24b. REGISTRAR'S SIGNATURE M. R. Etchison					
VS A15 (4) 15M 10/57				DATE							

DEPARTMENT OF THE NAVY - UNITED STATES GOVERNMENT

MAILED TO STATIONED COUNTRY

1907A. JOURNAL

2025



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

117942

7944 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Fredrick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Fredrick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fredrick</i>		c. LENGTH OF STAY IN 1b <i>11</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fredrick</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>722 N Market St</i>		d. STREET ADDRESS <i>1322 N Market St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Maurice</i>	Middle <i>L</i>	Last <i>Selar</i>	4. DATE OF DEATH <i>July 1 1959</i>	Month <i>July</i>	Day <i>1</i>	Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>May 5, 1892</i>	9. AGE (In years lost birthday) <i>67 yrs.</i>	IF UNDER 1 YEAR Months <i>27</i>	IF UNDER 24 HRS. Days <i>27</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Proprietor</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Junk</i>	11. BIRTHPLACE (State or foreign country) <i>Poland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Jacob</i>	14. MOTHER'S MAIDEN NAME <i>Macka</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Freida Selar - Same</i>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rheumatic Heart Disease</i>							
416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md</i>	
21. I certify that I attended the deceased from <i>12/14</i> , 19 <i>51</i> , to <i>July 1</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>June 29</i> , 19 <i>59</i> , and that death occurred at <i>8:15 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>S. R. Sabourin</i>	ADDRESS (Street, city or town, state) <i>225 N Market St Baltimore Md</i>						DATE SIGNED <i>7/1/59</i>
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>7-2-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Rosedale</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>	(State) <i>Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i>	ADDRESS <i>2100 Eastern Pl</i>	24a. REC'D BY REGISTRAR DATE <i>JUL 6 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>				
VS A15 (4) 1SM 10/57							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7945 CERTIFICATE OF DEATH

Reg. Dist. No.

07943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Frederick				c. LENGTH OF STAY IN 1b 11					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 514 Fairview Avenue				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					
3. NAME OF DECEASED (Type or print)		First Albert	Middle Miles	Last Scott	4. DATE OF DEATH July 27	Month July	Day 27	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> Never married		8. DATE OF BIRTH 4-7-1911	9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Confectionery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Grant Scott				14. MOTHER'S MAIDEN NAME Alice Miles					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-10-1669		17. INFORMANT Mrs. Albert M. Scott-514 Fairview Ave.-Frederick		Address Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Coronary heart dis. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1957									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. g. p. m.		Month July	Doy 27	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Professional Bldg.	(County) Frederick	(State) Maryland
21. I certify that I attended the deceased from Sept 4 , 1958, to 27 July , 1959, that I last saw the deceased alive on 27 July , 1959, and the death occurred at 7:40 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Charles H. Conley, Jr. M.D. ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED 1959									
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley-Jr.		Frederick- Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-1959		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick			
23. FUNERAL DIRECTOR'S SIGNATURE Daileys Funeral Home		ADDRESS Frederick- Maryland		24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF

DEATH CERTIFICATE

State of Missouri

Date: 2023

County: St. Louis

Municipality: St. Louis

Address:

City: St. Louis

Name of deceased:

Signature of physician or medical examiner

Sex: M

Race: White

Age: 65

Cause of death: Heart disease

Date of death: June 15, 2023

Place of death:

Hospital

Name of physician or medical examiner:

Signature of physician or medical examiner:

Name of hospital or place of death:

Signature of hospital or place of death:

Name of funeral home:

Signature of funeral home:

Name of coroner:

Signature of coroner:

Name of attorney:

Signature of attorney:

Name of next of kin:

Signature of next of kin:

Name of informant:

Signature of informant:

Name of coroner:

Signature of coroner:

Name of attorney:

Signature of attorney:

Name of next of kin:

Signature of next of kin:

Name of informant:

Signature of informant:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7946 CERTIFICATE OF DEATH

Reg. Dist. No. 07944

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick-Rural-R.F.D.#7				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Rocky Springs		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle HUGH	Last SIMMONS	4. DATE OF DEATH July 26 1959	Month July	Day 26	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH December 22, 1904	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Club		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert Sherr Simmons			14. MOTHER'S MAIDEN NAME Mary Anna Simmons					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-9128		17. INFORMANT Mrs. Ruth Cline Simmons-Same as Item #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO 581.0 INTERVAL BETWEEN ONSET AND DEATH 12 hrs. Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause first. (b) Varish pneumonia DUE TO 4 days (c) Chlorosis & liver DUE TO 5910+								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month July	Day 22	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Professional Building	(County) Frederick	(State) Maryland
21. I certify that I attended the deceased from July 22, 1959 to July 26, 1959 , that I last saw the deceased alive on July 22, 1959 , and that death occurred at 7:45A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE B. O. Thomas ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 7/28/59								
PHYSICIAN'S NAME (Type) B. O. Thomas, M.D. Frederick, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 30, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick,	(State) Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 29 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7947 CERTIFICATE OF DEATH

Reg. Dist. No.

17945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 18 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 207 S. Market St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary J. Staub		First	Middle	Last	4. DATE OF DEATH July 20	Month	Day	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1888		9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Scott Grimes			14. MOTHER'S MAIDEN NAME Minnie Frock					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 185-28-2112		17. INFORMANT Mrs. Leroy Hann		Address Md. 207 S. Market St. Fred.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolus</i> 466 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Phlebo thrombosis, right</i> DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH Minutes & 3 days ? weeks								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Woodsboro, Maryland	(County) Frederick	(State) Maryland
21. I certify that I attended the deceased from <u>1 July</u> , 19 <u>59</u> , to <u>20 July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>20 July</u> , 19 <u>59</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>James B. Thomas,</i>		ADDRESS (Street, city or town, state) <i>278 N. Market St., Frederick, Md.</i>						
PHYSICIAN'S NAME (Type) M.L. Creager & Son		DATE SIGNED <i>7/20/59</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Woodsboro, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jay Creager & Son</i>		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE JUL 27 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>		

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www.wiley.com/go/krishnamoorthy

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7948

CERTIFICATE OF DEATH

Reg. Dist. No.

07946

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Roy</i>		First <i>R</i>	Middle <i>Y</i>
4. DATE OF DEATH <i>STRAWSBURG</i>		Last <i>S</i>	Month <i>JULY</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>2-24-85</i>		9. AGE (In years, months, days, hours, min.) 74 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former at Hudson Supply Co. Buckeystown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Na. U.S.A.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Strawsburg</i>		14. MOTHER'S MAIDEN NAME <i>Ida Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>420.0</i>		16. SOCIAL SECURITY NO. <i>217-05-0888</i>	
17. INFORMANT <i>Mrs. Margie A. K. Strawsburg (Wife) Frederick,</i>		Address <i>Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Disease (Failure)</i> DUE TO <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO <i>Several years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Transitional Cell Carcinoma of Bladder</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>(County) (State)</i>
21. I certify that I attended the deceased from <i>2-26-1959</i> to <i>7-16-1959</i> , that I last saw the deceased alive on <i>7-16-1959</i> , and that death occurred at <i>2-45 PM</i> . From the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert D. Crouch</i>		ADDRESS (Street, city or town, state) <i>Shopping Center, Frederick, Md.</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT D. CROUCH</i>		DATE SIGNED <i>7/16/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 19, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>		22d. LOCATION (City, town, or county) <i>(State) Frederick, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert D. Crouch</i>		ADDRESS <i>Frederick, Maryland</i>	
		24a. REC'D. BY REGISTRAR <i>JUL 21 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur & Thane</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7949 CERTIFICATE OF DEATH

Reg. Dist. No.

07947

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		d. STREET ADDRESS East Main Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Guy	Middle P.	Last Waters	4. DATE OF DEATH	Month July	Day 18, 1959	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 25, 1887	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Hours 22	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? United States				
13. FATHER'S NAME James Kinna Waters	14. MOTHER'S MAIDEN NAME Laura Leatherman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-34-1015	17. INFORMANT Mary Y. Waters, Middletown, Md.	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis DUE TO (c) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic gangrene at lower extremity.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)		
21. I certify that I attended the deceased from 14 July , 1959, to 18 July , 1959, that I last saw the deceased alive on 18 July , 1959, and that death occurred at 10 a.m. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Melvin E. Lea				ADDRESS (Street, city or town, state) 35 East Church St			
DATE SIGNED 18 July 1959							
PHYSICIAN'S NAME (Type) Melvin E. Lea MD		Physician's Signature Frederick, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 21, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Lutheran	22d. LOCATION (City, town, or county) Middletown, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Maryland	ADDRESS	24a. REC'D BY REGISTRAR Arthur S. Hayes	24b. REGISTRAR'S SIGNATURE				
		DATE JUL 22 '59					

TO HOSPITALS: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INSTRUCTIONS

TO ATTEND physician or hospital may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07948

7965 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY	Frederick MARYLAND			STATE	Maryland COUNTY Frederick		
CITY (If outside corporate limits, write RURAL OR and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN	Rural Urbana	LENGTH OF STAY (in this place)	20 Years	TOWN	Rural Urbana	(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Urbana			STREET ADDRESS	Urbana Lived On Farm Yes		
3. NAME OF DECEASED (First) William (Middle) Andrew (Last) Webb				4. DATE OF DEATH July 10 1959			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Widowed	Jan. 9 1881	78 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Ret. Farmer			Own Farm	Virginia			U.S.A.
13. FATHER'S NAME Joseph Webb				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no.) No			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Rt 1			
			Unknown	H. Hyter Webb Gaithersburg, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE		(A)		Baccho pneumonia		3 days	
ANTECEDENT CAUSE(S)		DUE TO		Cardiovascular disease		5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		(B)		Arterio sclerosis		5 years	
STATING UNDERLYING CAUSE LAST.		DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1959, to July 10, 1959, that I last saw the deceased alive on July 9, 1959, and that death occurred at 7 A.M. from the causes and on the date stated above.							
SIGNATURE <i>John Thomas</i> ADDRESS (Street, city, town, state) <i>Frederick, Md.</i> DATE SIGNED <i>7/11/59</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 13		NAME OF CEMETERY OR CREMATORIAYaytonsville Meth.		LOCATION (City, town, or county) Laytonsville, Md. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Arthur & Kline</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Roy W Barber</i>		ADDRESS Laytonsville, Md.	
DATE JUL 14 '59							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7966

CERTIFICATE OF DEATH

07949

Reg. Dist. No.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO HOSPITAL: may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson		c. LENGTH OF STAY IN lb years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Jefferson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary C. Young		First	Middle	Last	4. DATE OF DEATH Month 7	Day 10	Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wallace G. Everhart				14. MOTHER'S MAIDEN NAME Effie E. Everhart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
no		none		Clarence Young, Jefferson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Myocardial Infarct DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from No. attending Dra. Talbot Briece , that I last saw the deceased alive on July 12, 1959 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE B.O. Thomas		M.D.		Frederick, Md.		July 12, 1959	
PHYSICIAN'S NAME (Type) B.O. Thomas, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/13/1959		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE JUL 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

J900 CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE
EDWARD J. KELLY	60	M	APRIL 10, 1950
ADDRESS OF DECEASED			
1015 N. 10TH ST., MILWAUKEE, WIS.			
NAME AND ADDRESS OF DOCTOR			
DR. JAMES J. KELLY, 1015 N. 10TH ST., MILWAUKEE, WIS.			
NAME AND ADDRESS OF FUNERAL DIRECTOR			
MURRAY & SONS, 1015 N. 10TH ST., MILWAUKEE, WIS.			
TIME OF DEATH			
10:00 A.M.			
CAUSE OF DEATH			
HEART DISEASE			
METHOD OF DEATH			
NATURAL			
NAME OF PERSON SIGNING			
EDWARD J. KELLY, M.D.			
SIGNATURE			
EDWARD J. KELLY, M.D.			
DATE			
APRIL 10, 1950			